GBMC
6701 North Charles Street
Baltimore, MD 21204

Joint Replacement: Discharge Planning Questionnaire

This information is a vital part of our hospital's plan to provide the best follow-up care possible for you.

Name:_____ Date of Birth:___/___/_____ Age:_____

Address:_____ Phone # (home)_____

_____ (Cell)_____

Email Address: _____

Type of surgery (circle one): **Partial Knee**: Right Left **Revision**: Right Left

Total Knee Replacement: Right Left Bilateral

Total Hip Replacement: Right Left Bilateral

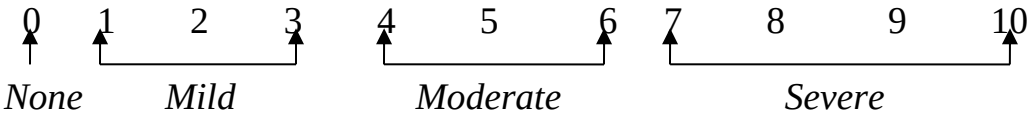
Date of Surgery:_____ Name of Surgeon: _____

Any citrus allergy? Yes **or** No Any history of nausea or vomiting after surgery? Yes **or** No

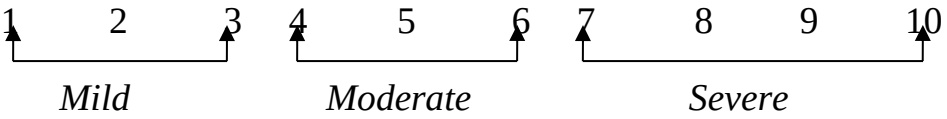
Any history of having methicillin-resistant staphylococcus aureus (MRSA), Staph Aureus infections, or boils on the skin: Yes or No
(if yes, where and when?)_____
Any history of urinary retention, enlarge prostate, pelvic prolapse? Yes or No

Preferred Pharmacy:_____ Phone #:_____

Current pain level (0-10) Please circle where you would rate your ***pain level at this time***-



Please circle **pain goal** *after surgery* (A score of "***0" is not an option***)



Please state your reason(s) for reaching this pain goal: (ex: *"I want my pain level to be a 3 out of 10 so that I will be able to bend down and kneel to garden, again.*") _____

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